Family Medicine in Nigeria: The Journey, Challenges, and Future Prospects

Akinwale Moses[1]

1. Department of Family Medicine, National Hospital, Abuja

Corresponding Author
Name: Akinwale Moses,
Department of Family Medicine, National Hospital, Abuja

Abstract

Family Medicine in Nigeria has evolved from humble beginnings to become a vital component of the nation's healthcare system. This review article provides an in-depth analysis of this journey, highlighting the contributions of pioneers and current leaders who have shaped the speciality. It emphasises the importance of Family Medicine as a cornerstone of Nigeria's healthcare system, advocating for increased public and stakeholder awareness of its role and benefits.

The historical context of Family Medicine worldwide can be traced back to its roots in General Practice (GP), which evolved into a recognised speciality in 1969. The establishment of the National Postgraduate Medical College of Nigeria (NPMCN) and the inclusion of General Medical Practice (GMP) as one of its faculties marked a significant milestone. The transition from GMP to Family Medicine is well documented, with the adoption of a training curriculum and the eventual renaming of the faculty to Family Medicine in 2006.

Current challenges facing Family Medicine in Nigeria include low awareness, weak primary healthcare systems, inadequate collaboration with health stakeholders, and insufficient training and resources. The document advocates for policy reforms, improved infrastructure, and strengthened cooperation to address these issues. It also emphasises the necessity for standardised operating procedures, increased credit units for training, and a larger number of family physicians to meet the country's healthcare needs.

In conclusion, it is necessary to build a future where Family Medicine plays a pivotal role in Nigeria's Primary Healthcare and overall healthcare system. We advocate for the Society of Family Physicians of Nigeria (SOFPON) to collaborate with relevant agencies to facilitate the accreditation of FM programmes, the establishment of Family Medicine undergraduate programmes in all the nation's universities, and residency training programmes throughout the country's secondary and tertiary care centres. The document emphasises the importance of public awareness, research, and active participation in health management to enhance the speciality's relevance and impact.

Keywords: Family Medicine (FM), General Practice (GP), Healthcare, SOFPON, Nigeria

Introduction

Family Medicine, a relatively recent area of medical specialisation in the world, emerged in the 1960s in the UK and the US as a response to a recognised need in personal healthcare with emphasis on a holistic approach to management of common diseases and ailments[1,2]. Since then, it has expanded to various parts of the globe, significantly enhancing healthcare systems worldwide by emphasising holistic, preventative care and fostering enduring relationships with patients and their families. This approach improves primary care, increases the capacity of the healthcare workforce, and strengthens community health services. Furthermore, Family Physicians play a vital role in linking healthcare with social determinants of health, advocating for health equity, and improving patient safety.[1] Countries with strong primary healthcare systems, particularly in the developed world, such as Europe, the UK, the US, Australia, and Canada, achieve superior outcomes compared to those in middle and low-income nations, as their populations experience greater patient satisfaction, fewer hospitalisations, and lower healthcare costs.[1,3]

Family Medicine has risen from the ground level to become a trailblazer, a beacon of hope, and a definitive answer to the future of Nigeria's healthcare system.[3,4] Appropriate opportunities should always be utilised to enhance public and stakeholder awareness and understanding of the role of Family Medicine and Family Physicians (FP) in Nigeria. Who are we? Where are we coming from? What have we achieved? What is our future, and how do we get there? FPs must continue to sustain and elevate their esteemed position earned through exceptional hard work and dedication. After all, FPs are the first point of contact and frontline physicians.[5]

The vision and sacrifices of the founding fathers of Family Medicine in Nigeria, who planted the seeds of the remarkable fruits we enjoy today, are greatly recognised and appreciated. We fondly remember Dr Andem Ewa, Dr Yinka Olumide, Dr A.O. Ajayi, Dr S.E. Mbanefo, Dr Okojie, Dr Adeleye, Dr Egbuonu, Dr Azike, Dr Andrew Pearson, Dr Mama, Dr Elukpo, Dr Kalejaiye, Dr Sam Oloruntoba, and Dr Ayodeji Sangowawa, among others, for their selfless services to the faculty.

The efforts of those who have gallantly continued to advance the frontiers of Family Medicine in Nigeria are greatly appreciated. This list includes: Dr Tor-Agbidye, Dr Abioye Kuteyi, Dr Victor Inem, Dr Ndifrike Udonwa, Dr Kofo Odusote, Dr Modupe Ladipo, Dr ML Shehu, Dr Anthony Nwajei, Dr Stephen Yohanna, Dr Paul Obiegbu, Dr Emmanuel Amao, Dr Ita Bassey Okokon, Dr Ike Ajayi, Dr

Paul Dienye, Dr Michael Obadofin, Dr Paul Ushie, Dr Matie Obazee, the late Drs Damien Uyagu and Adenike Adeniran, Dr Adekemi Fadipe, Dr Ayo Olofin, Dr Ogunseye, Dr Adekunle Ariba, Dr Aboi Madaki, Dr Jonah Abah, Dr Amos Okedare, Dr K Alabi, Dr Olupona, Dr I. S. Bello, Dr Timothy Odeleye, and Dr Akin Moses.

We are fully assured and encouraged by the selflessness, dynamism, and enthusiasm of those currently in leadership positions on various fronts. Some of our members have held, and continue to hold, key positions in the Postgraduate Medical Colleges: Professor Aboi Madaki has just completed his term of office as Vice President of the West African College of Physicians (WACP) and Chairman of its Nigeria Chapter, where he served meritoriously. Professor Musa Dankyau is the current Secretary General of WACP, Dr Achiaka Irabor is the Director of the Doctors as Educators programme (WACP), and Dr Sunday Malomo is the National Secretary of the WACP Nigeria Chapter. Dr Osahon Enabulele served with distinction in the various offices he held as President of the Nigeria Medical Association, Commonwealth Medical Association, and World Medical Association. At the same time, Dr Bello Ibrahim is the current Editor-in-Chief of the Nigerian Frontline Medicine Journal (NFMJ) and the Nigerian Journal of Family Practice (NJFP).[6,7] Many Family Physicians in Nigeria serve as Chief Medical Directors of Teaching Hospitals, Deputy Vice Chancellors, Ministers at the federal level, Secretaries to State Governments, Permanent Secretaries, and Commissioners for Health, among others. We have every reason to be proud as family medicine continues to be impactful.

Our esteemed Family Physicians have selflessly and willingly dedicated their time, energy, and financial resources for the welfare of our colleagues, the advancement of Family Medicine, and the consolidation of our standing. Our recent successes reflect the strength of unity and togetherness, which we must continue to nurture. However, the online meetings have deprived us of our cherished face-to-face gatherings, where we cultivate enduring relationships, social networks, and emotional bonds.

Global evolution of Family Medicine

Family Medicine, known in different parts of the world as General Practice, Family Practice, and community-oriented clinical practice, was officially recognised as a speciality in 1969.[8,9] It is the oldest speciality in existence.[9] Centuries ago, when humans lived in small settlements and low-density environments, conventional forms of healthcare did not exist. Expert generalists lived close to their patients, and a single generalist doctor could effectively treat common illnesses, set fractures, deliver babies, and care for children and those with abnormal behaviours.

The expert generalists were well-acquainted with their patients and families; healthcare costs remained low, community care was readily accessible, and patient satisfaction was high. The doctors welcomed everyone seeking care and did not restrict access to their services based on age, gender, stage, or type of disease. The aim, then, was to evaluate and address the overall health needs of individuals and their families.

Over time, physicians began to specialise, and patients with multiple issues required different specialists, necessitating visits to various locations. The fragmentation of medical care became a significant problem, leading to the unavailability of general practitioners and considerable dissatisfaction. Fortunately, by 1966, three published reports (The Folsom report, The Millis report, and The Willard report) made compelling arguments for what is now known as Family Medicine. They advocated for replenishing the dwindling number of general practitioners with primary care physicians who would provide comprehensive, continuous, coordinated care and preventive services. A training programme for a new kind of board-certified specialist – The Family Physician – was also outlined.[10]

Evolution of Family Medicine in Nigeria:

Four years after the publication of these reports, the Medical and Dental Council of Nigeria established the National Postgraduate Medical College of Nigeria (NPMCN) with 14 faculties by military decree in 1970.[7] Fortunately, General Medical Practice (GMP) was among them. The inclusion of GMP stemmed from the necessity to train primary care physicians who would adapt their knowledge, competence, and skills to the unique and challenging environment of a developing country like Nigeria.[11] The specific broader health needs of Nigeria, coupled with the limited number of specialists in other fields, also necessitated a realistic conceptual framework.

At that time, however, there were no relevant structures or GMP specialists available to commence formal training. Fellowship of the Medical Council in GMP was conferred upon any doctor deemed suitable for such an award. Between 1976 and 1980, the Association of General Private and Medical Practitioners of Nigeria (AGPMPN), now known as the Association of National Private and Medical Practitioners (ANPMP), established an academic subcommittee to coordinate CME programmes. This led to the formation of a GMP Faculty Board at the NPMCN, which was tasked with preparing a syllabus, vocational training scheme, and examination format for the fellowship programme in GMP. There was liaison with the Royal College of GPs in England

and close collaboration with Late Dr Andrew Pearson.[12]

Paradigm shift to Family Medicine: Following the International Conference on Curriculum Review (ICCR) in Ibadan in 1980, the NPMCN adopted the training curriculum, and postgraduate training in GMP commenced in 1981. In response to the global call by Wonca (World Organisation of Family Doctors) addressed to all colleges, academies, societies, and associations of general practitioners with postgraduate speciality programmes, the nomenclature GMP was changed to Family Medicine in 1998, following the resolution of the ICCR held in Ota, Nigeria.

The ICCR recommended that individuals and families should become the key focus of Family Medicine training in West Africa. This addressed the identity crisis of differentiating between those with basic degrees and those who have acquired specialist qualifications while also ensuring a paradigm shift towards the appropriate domain of the biopsychosocial and patient-centred model of care. However, it was not until 2002 that the WACP changed the name of the Faculty of GMP to the Faculty of Family Medicine, and in 2006, the faculty in the NPMCN followed suit.[13]

Current Status: Today, 83 institutions are accredited for Family Medicine residency training programmes in Nigeria. We also conduct a tutelage programme for senior residents in 26 institutions, where they are expected to acquire skills in private practice management. Numerous West African countries have adopted the programme, including Ghana, Sierra Leone, Liberia, The Gambia, Côte d'Ivoire, the Benin Republic, and Togo.

We have over 1000 fellows qualified by examination working in various institutions both domestically and abroad. Many of our fellows have been appointed to academic positions at our universities and tertiary hospitals and are now Professors of Family Medicine. This was achieved due to the mandate given to medical schools in Nigeria by the National Universities Commission (NUC) in 2005 to establish undergraduate departments of Family Medicine.[14]

Commencement of the DFM programme: The postgraduate diploma in Family Medicine training programme commenced in May 2011, following approval from the Senate of the NPMCN. Thus far, the programme has produced 762 diploma holders in Family Medicine.

The conceptualisation of this programme was a strategic response to the need for an increased number of first-contact physicians with formal training in comprehensive, coordinated, and continuous care. The programme targets non-specialist physicians and specialist doctors in other medical fields who wish to acquire relevant knowledge and skills in Family Medicine. The certificate and transcripts from this commendable programme have been extremely beneficial for diplomates seeking further training and employment opportunities beyond the borders of Nigeria.

The issues surrounding appropriate positioning in the SOFPON executive leadership, MDCN categorisation, and exemption from the primary examinations of the NPMCN have hindered enthusiastic participation by the intended beneficiaries. However, deliberate efforts have been made to enhance the programme by implementing a well-structured curriculum, a logbook, and a thorough review of the part one clinical training activities for those with the postgraduate diploma certificate.

Importantly, let us commend the foresight and selflessness of the pioneers of this programme, who initiated the construction of a significant faculty building as an investment project located within walking distance of the Lagos University Teaching Hospital. I want to urge the current faculty board of the NPMCN to facilitate the swift completion of this structure.

Formation of the Society of Family Physicians of Nigeria (SOFPON): The association, now known as SOFPON, serves as an umbrella organisation for all Family Physicians practising in Nigeria, regardless of their training background. The concept of establishing an association for Family Physicians in Nigeria first emerged in 1995, during the April GMP Fellowship examination of the WACP in Ibadan. This originated from the necessity for an association to promote the cause and interests of Family Physicians.

The association was initially called the Academy of Family Physicians of Nigeria (AFPON), and it was launched in April 1998 during the ICCR titled "Training the frontline doctors for the 21st century" and held by both colleges at the Gateway Hotel, Ota. The conference involved over 90 delegates from many countries, including the UK, USA, India, S/Leone, Ghana, The Gambia and Nigeria. The Mission of SOFPON is "improving the health of individuals, families and communities in Nigeria, through the academic and professional advancement of the speciality of family medicine in Nigeria".[15]

LIST OF PAST AFPON & SOFPON PRESIDENTS AND SECRETARY-GENERALS

Date	President	Secretary General
1998-2004	Dr. Samuel Oloruntoba	Dr. Modupe M-A. Ladipo
2005-2008	Dr. Alan Fatayi-Williams	Dr. Adekunle Ariba
2009-2011	Dr. Matie Obazee	Dr. Taiwo Sogunle
2012-2014	Dr. Paul Dienye	Dr. Godswill Nnaji
2015-2017	Dr. Akin Moses	Dr. Blessing Chukwukelu
2018	Dr Musa Dankyau (Ag. President)	Dr Achiaka Irabor
2019-2021	Dr Nnadozie P Obiegbu	Dr Achiaka Irabor
2022-2024	Prof Musa Dankyau	Dr Sunday B. Udoh
2024-Till Date	Dr Mrs Blessing Chukwukelu	Dr Jatau Loh Ahmed

CHALLENGES

Limited recognition: Family Medicine in Nigeria is growing but remains largely unnoticed by the public and healthcare stakeholders. Many healthcare professionals view family medicine not as a distinct speciality but as comprising elements of other specialities, resulting in ambiguity regarding its role. Only 20% of medical students in a Nigerian medical school can accurately define family medicine. However, it has made significant strides in recent years.[16,17]

Policy reforms by the Federal Ministry of Health are essential to prioritising family medicine as the foundation and key to a rewarding healthcare system. There is undoubtedly an urgent need to raise public awareness about family medicine to promote preventive care, reduce healthcare costs, and improve health outcomes.

Weak Primary Health Care: Strengthening the primary healthcare systems to achieve universal health coverage will provide a solid foundation for family medicine to thrive. Availability and accessibility to basic health services remain a significant problem. Most consumers still pay out of pocket, as the scope of health insurance services is limited. This situation negatively impacts health-seeking behaviours and the provision of quality care by Family Physicians.[16]

As multicompetent specialists with polyvalent skills, Family Physicians' work is primarily at the primary and secondary care levels, where most of the population and diseases are found. The government needs to improve infrastructure and resources, including technology and equipment, to support the delivery of quality care by Family Physicians at these levels.

Poor collaboration with health stakeholders: The Family Physician's responsibilities include coordinating comprehensive, continuous, and patient-centred services and engaging in training and research activities at the tertiary care level. Unfortunately, the relevant healthcare stakeholders and colleagues in other specialities and allied fields do not fully understand the role of Family Physicians. Stronger collaboration and integration with other healthcare stakeholders and primary healthcare systems are essential.[17,18]

Lack of Standard Operating Procedure (SOP) guidelines: There is an urgent need for a common strategic position to consolidate our relevance and professionalism in tertiary medical institutions. Our speciality's SOFPON Executive and elders should develop an SOP document to guide our clinical activities and operations in these institutions. Let us clearly define the standard and acceptable functional units in any accredited department of family medicine. There is a critical need to articulate the objectives of each unit of the functional department of family medicine so that every accredited department will understand why they need to have these units. The SOP should include routine outpatient services, point of care services, basic procedural services, emergency services, inpatient services, training facilities, areas of special interest clinics, adjoining integrated rural health training posts, and other preventive clinical services. This will guarantee uniformity and consistency and ensure the acquisition of expected knowledge and skills.[16]

Inadequate credit unit allocation by the NUC: Although the NUC mandated medical schools in Nigeria in 2015 to establish undergraduate departments of family medicine, the scope of credit units and training contents approved in the CCMAS is highly limited and needs urgent review. This usually creates bottlenecks during accreditation by the MDCN and the granting of full departmental status to family medicine by university institutions.[17]

There is an urgent need by the current SOFPON Executive to set up a committee to intervene at NUC and MDCN to facilitate the establishment of undergraduate family medicine (UFMD) departments and not units under other departments. More medical schools should be encouraged to establish UFMD to improve awareness and acceptability.

Inadequate number of Family Physicians: The number of Family Physicians currently practising in Nigeria, compared to the country's population and expected health outcomes for patients/people, is very low. We need an appropriate type and number of physicians to provide community-based clinical care for acceptable health indices. Our leaders in the various SOFPON zones should identify and recommend suitable health facilities to the colleges for accreditation to produce more Family Physicians for quality service delivery, training and research. We need a critical mass of Family Physicians to make significant impact within primary health care.

Trainees/trainers are not familiar with the curriculum and training handbook. There is also inadequate harmonisation of training methods and standards in the various accredited centres using the new curriculum, e-learning portfolio, accreditation checklist, and formative assessment tools of the colleges.

Poor implementation of areas of special interest in family medicine: The level of understanding, accommodation, and implementation of areas of special interest in family medicine is still low. There is poor appreciation of the need to set up areas of special interest clinics by accredited centres. Implementation will improve our relevance, consumer confidence, patient satisfaction and revenue generation for institutions.

Inadequate application of family medicine principles: The paradigm shift to family medicine from general medical

practice necessitates the application of biopsychosocial principles and patient-centred clinical methods to the management of our patients and families. We must strive to apply family medicine principles and tools in evaluating and managing patients and families compared to the traditional models of consultation and care.[16]

Low disposition to acquisition of surgical skills: One critical requirement of our speciality training is the acquisition of procedural and basic surgical skills for the adequate provision of services, especially at the primary and secondary care levels. There appears to be poor enthusiasm and disposition towards this requirement.

Low level of interest in SOFPON activities: A Family Physician is not only someone who has competence over a wide range of medical and surgical problems in the domain of family medicine, but also has the right attitude, orientation and behaviour towards the speciality. Every Family Physician is expected to be committed to the ideals, values and activities of SOFPON. However, there is low level of interest and participation in SOFPON activities at the local and national levels. Let us encourage ourselves using our potential and achievements. Let us improve on implementing our Strategic Plan, especially the committees, collaboration and financial sustainability plans.

Individuals also experience peculiar challenges during their training periods and current workplaces such as poor working environment, inappropriate training settings and skills acquisition facilities, lack of clearly defined roles and inappropriate deployment, inadequate opportunities for acquisition of surgical skills, inadequate support from the management, inadequate number of residents causing burn-out, lack of inpatient care experience, lack of consultant posts etc.

FUTURE PROSPECTS

Deliberate collaboration/partnership with the relevant agencies/bodies such as the National Health Insurance Agency, the National Primary Health Care Development Agency, the National Emergency Management Agency, the National Emergency Services, the National Youth Service Corps, the Council on Health, etc., to improve our visibility and community care services. Our colleges should partner with WONCA for accreditation to further validate our programs and performances.

We need to strengthen our SOFPON National Research-Based Network to regularly publish the impact of our work and specialisation on the nation's health outcomes. SOFPON should prepare a practical document on how to collaborate with the Federal Ministry of Health to manage the primary health care centres in Nigeria, aiming to enhance consumer confidence, improve the quality of services, and elevate health indices. Let us sensitise our government to Cuba's health model, which has one of the best health outcomes in the world and has been recommended by the World Health Organisation as an example for others. The primary care level in Cuba is community-based, rooted in the general family doctor and nurse model developed in 1984. Approximately 80% of cases are resolved at this level. The country's emphasis on preventive care and community-based medicine contributes to a more coordinated approach to primary health care.

While waiting for the outcome of our collaboration with the Federal Ministry of Health, a strong appeal is being made to the SOFPON executive to set up a committee to study and make appropriate recommendations to our accredited centres on the model of community-based medicine, practical implementation of special interest clinics and integrated rural practice by the department of Family Medicine, University College Hospital, Ibadan and the Family Medicine practice centre Gawu-Babangida, Niger State respectively. Undoubtedly, the experiences from these two centres will help us refocus the Nigerian Health system on the objectives and essential health needs advocated by family medicine.[17]

SOFPON can lead the initiative to conduct a study on the impact of the postgraduate diploma in family medicine program on our health care services since its commencement in 2015. In addition, SOFPON can prepare standardised protocols for managing common medical/surgical conditions and submit reviews to the Federal Ministry of Health every 2-3 years based on current best evidence from literature.

Given the spread of Family Physicians and diplomates across the country, obstetric life-saving skills and maternal health services can be improved in the local government areas by applying Advanced Life-Saving Obstetrics training, which should be a basic, compulsory and renewable skill for all primary care providers. The executive committee of the Society of Family Physicians of Nigeria (SOFPON) need to organise robust and rewarding in-person meetings, even if they occur only once a year, to deliberate on issues relating to enhancing the contribution of Family medicine to the nation's health system.[18]

SOFPON should collaborate with the West African Health Organisation/Economic Community of West African States to review the terms of the Technical Aids Corps (TAC) as it concerns Family Physicians in Nigeria to strengthen our workforce, facilitate job opportunities abroad, and encourage foreign exchange earnings.[19]

Collaboration with the National Council on Health/Governors' Forum is essential to identify suitable health facilities nationwide and establish family medicine

residency training programmes in each senatorial constituency. This will increase the number of Family Physicians, enhance the volume and quality of community health care services, and improve access to care. Building a critical mass of Family Physicians has been central to achieving better health outcomes in developed economies. Henceforth, there should be deliberate and active participation in health management and governance to influence our positioning, relevance and contributions to the health care system and citizens' welfare.

CONCLUSION:

Family Medicine is an evolving speciality in Nigeria, with few practitioners relative to the population. Building a critical mass of Family Physicians is essential to strengthening primary and secondary healthcare.[20] Their diverse skills can enhance health outcomes and quality of care.[20] Recently, Family Physicians have collaborated with partners to show their potential in improving the health system. Under SOFPON, Nigerian Family Physicians can become more cohesive and focused in repositioning family medicine in the country.

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